

Statement on Social Medicine

by

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The issues and interests of social medicine center around the questions: What can be done to extend the benefits of good medical care to a larger number of people? How can we best provide reasonable remuneration for physicians and allied professional personnel? How should the marketing of medical care be controlled? Is the individual physician the best judge or the best administrator of a system involving the distribution of medical care?

In these questions there is general agreement that medical art and medical science are extremely valuable when skillfully applied; that good medical care is expensive; that the quality of medical care and medical training should not suffer. But attitudes differ, expressed in varying shades of opinion, regarding such questions as: How can the physician's services be organized for rendering care of good quality at reasonable cost? Who should determine the organization of medical care and who should fix the cost thereof and how it shall be paid? And what ought to be the criteria or basis for receiving medical care? One is reminded of Napoleon's observation that you should send an expert to do a job and then send a layman after him to see if it's well done.

On the one side of the argument are those who accept, as they believe, the lessons of the past. They hold that human nature has always been the same, that the relationship of physician to patient is personal and inviolable, brooking no interference from outside, that the patient must be free to choose his physician and the physician free to deal with his patient as he thinks best, that the best government is no government, that modern man is rational, free and

able to choose what is best for him and that he must live by the sweat of his brow and not seek protection from the State "from the womb to the tomb."

On the other side are those who challenge the lessons of the past as a sole guide for the potentialities of the present, who believe that the conditions of medical practice, as well as its content, have changed and that new arrangements are called for, that group practice provides better care than individual practice, that medical care should be distributed more wisely, more economically and more efficiently by some measure of control in its administration, improvement of its quality and a collective responsibility for its cost.

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That medicine has greatly progressed is a truism. What is not understood is that this progress has extensive corollaries. Progress in medicine offers two great advances: one, that the causes of many diseases have been determined exactly; and the other, that many new forms of treatment have been found to relieve or to cure diseases whose cause is known or still unknown. By so much, too, as one knows the exact primary cause of the disease it has been possible to recognize secondary or contributing causes. As an example, the exact cause of what used to be called consumption is now known to be the tubercle bacillus. The real fall in the rate of tuberculosis began shortly after Koch's discovery of that bacillus and its role as a primary cause of tuberculosis. Overcrowding and the resulting inhalation of dried sputum became recognized as a contributing or favoring secondary cause of the development of tuberculosis. The treatment of cancer by radium or x-ray is an example of improved treatment of a disease whose exact causation is still unknown. The number of diseases whose precise causes have been discovered in the last fifty years is very large. The number, also, of drugs or other therapeutic agents of proven efficacy has

also grown to a formidable degree. Thus the physician of today is equipped to give services that are at once more varied, more comprehensive, and more preventive as well as more effective than in times gone by.

Blended with the progress in the efficiency of medicine and surgery and also antedating it, runs the hospital tradition - one might say the Christian tradition - of charity in giving medical aid to the poor and to the unfortunate. This tradition is so obvious that we need not pause to establish its reality, but rather proceed to note the way in which an evolution has come to hospital services. There has been progress in the treatment of the unfortunate in hospitals. Hospitals have purchased expensive equipment. Hospitals have not only enabled but encouraged specialization, and the overhead expense of costly equipment and specialization have found justification in hospitals by the increase in the volume of patients treated. Business men have come on the boards of trustees in hospitals in increased numbers and the career of hospital superintendent has been opened to laymen who have looked upon the hospitals' efficiency in terms of cost and distribution of services. Hospitals started from the motive of religious piety have emphasized of late years business efficiency. Starting as charitable institutions caring for the poor they have become scientific institutions rendering medical care to all groups of society. This change has not failed to influence physicians and patients in their attitudes toward disease. Not only has there been this change in hospital work, but concurrently there have developed in the business life of the country the changes that have characterized public utilities, which have slowly but surely learned that services of essential importance to many citizens must be rendered with an eye to "public relations." Manufacturing has tended increasingly towards the methods and the outlook of mass production, with its inevitable recognition that

the weakest link is likely to be distribution rather than the costs of manufacture of a well-standardized product. In the past fifty years the principle of insurance has gained wider and wider acceptance, so that we see all around the physician and his work examples of efficient organization in other fields of activity that set interesting and at times cogent examples. If other forms of loss and danger which strike unpredictably and unevenly can be mitigated, why cannot illness costs be spread too by insurance?

Thus the doctor is faced with new preoccupations and responsibilities which are in effect corollaries of his increasing mastery of disease. In the past the physician's services were set in motion by pain or disability bringing the patient to the doctor. Now we see in increasing measure the doctor himself deciding when and how to mobilize science in behalf of the lay public before it is either diseased or disabled. We even see the concern of the physician to assist his patient to reach an optimum of performance - e.g., the flight surgeon tries to select and maintain optimum performance in the flier. The modern physician is not inclined to accept disease with resignation or fatalistically. His competence excuses him from so passive a role. In the past much of the doctor's work was really uncertain, groping effort. It was not highly technical nor was it very costly. Morris Fishbein says that 85 per cent of the cases seen by the ordinary doctor can be treated with what the doctor carries in his bag. I doubt this statement since there is no question that therapeutic agents - x-ray, bio-chemical tests, radium, surgical devices and the administration of effective but dangerous drugs - are all more costly, more technical, more frequently used, and more efficient than in days gone by. The old-style physician was generous and accommodating. He spent much of his time on the way to and from persons sick in their homes. His practice was usually a general practice and his life

and his relationships were individualistic. Nowadays it is obvious that a physician, at least in the cities, works best in collaboration, is himself specialized and expects rightly that his patients will come to him or better to his group for their diagnosis and their care. Certainly the trend of medicine reaches towards prevention, towards technical services and costly equipment, towards specialization, centralization and collaborative effort.

What makes up medical care? It has a personal aspect and a scientific aspect. The personal side of medical care involves the doctor's knowledge of the patient's surroundings, his job, his ties, his ambitions, his fears, his obligations, his past, his character. The scientific part of medical care concerns the physician's control of the disease, its diagnosis, treatment and the prevention of spread or recurrence. Scientific medical care depends upon access to and skill in the use of medicine, apparatus and laboratory procedure.

At the present time the rich get good personal care nearly always and good scientific care usually. The poor get good personal care only very rarely but often good scientific care in the cities though in rural areas only in a very small proportion of instances relative to their number. The middle class gets good personal care usually and poor scientific care usually, since it is the foible of the middle class to insist on appearances at the expense of real value.

Now in the light of the present capacities of the doctor, the layman expects good performance from the doctor and the layman realizes that medical competence is dependent upon training and facilities and that both these cost money. The layman also expects that the physician's services will be available -- available in the double sense of being within reach of his purse and being within reach of somebody's automobile, his own or the doctor's.

Just insofar, then, as medicine has secured reliable and efficacious knowledge of the causes of diseases and of effective ways to cure diseases, the physician is now finding himself in a changed relationship to the rest of society. The old-school practitioner with services which made up in patience, generosity, and sympathy, what they necessarily lacked in science and effectiveness, is being succeeded by a doctor whose services are more effective, more real, more business-like, more costly and yet more sought after. The modern physician has a more definable and more verifiable service to perform. He is more valuable to people and valuable to more people than before. Because the doctor's services are purchasable and yet almost beyond price they are coming to be regarded like life, liberty and the pursuit of happiness - a civic right, a public necessity.

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The issues of social medicine pertain to the geographical accessibility and economic accessibility and to the organization and method of support of medical services. Obviously each of these factors influences the others. In the United States, though the ratio of doctors to population is high, it is not uniform and the large cities show a far higher ratio of doctors to population than the rural areas. If one considers also such facilities as hospitals, the discrepancy between the availability of good medical care in city and country constitutes a very serious criticism of the distribution of medical services to the population as a whole. As to the economic availability of physicians one notes the paradoxical fact that the average physician's income is too low in relation to the cost of his training and the value of his professional time. And yet the cost to the patient of medical services is higher than a large proportion of the population can afford. In point of the organization of medical

service the essential dispute concerns the freedom that a physician should have to determine the conditions under which he will exercise his expertness. More than the mere geographical distribution of physicians, but closely related to it, the major issues of social medicine concern the economics and the organization of medical care.

In the light of these issues much of the demand for social medicine comes very naturally from the lay public and the reluctance to change comes largely from the conservative medical organizations. The consumer of medical services finds their distribution wasteful, inefficient and costly. Not a few physicians agree with this criticism since they see the traditional and established system failing to reach large numbers of the population, especially the low and middle income groups and those living in the country. They realize, too, that the traditional system fails to reach the middle class adequately and makes only rarely an economical use of the physician's long training and expensive equipment.

Why is it that social medicine is discussed so incessantly and insistently nowadays? Several reasons exist for this: The demands of Army and Navy for able-bodied young physicians have created a scarcity of doctors. Added to this, the growth of communities devoted to war industries has been swift and disordered and the number of available doctors in such communities is dangerously low, thus calling for a better organization of the services doctors can render. Increasing taxation is reducing the margin from which hospital bills and physicians' fees are paid and probably reducing the gifts received by voluntary hospitals from loyal and hitherto affluent donors. Furthermore, physicians have become accustomed in larger numbers to accepting salaried positions in industries and in the government agencies created to combat the depression.

Certainly the success of group practice which has extended considerably since its conspicuous demonstration at the Mayo Clinic has taught many physicians the advantages of collaboration and specialization. Probably the full-time teaching organizations in the medical schools have demonstrated the effectiveness (indeed in some instances the ideal effectiveness) of medical practice under varying degrees of supervision and control. In effect the medical schools are already conducting group practice. Of all these factors the most clamant and forceful are those of the wartime demands and the increase in taxation. By so much as these two conditions become intensified the likelihood of change in the practice of medicine becomes more certain.

What is the technique of social medicine? Just how would it work? Perhaps the existing institution nearest in methods and technique to social medicine is a medical school's teaching hospital. The doctors there are on salary, their work is specialized yet collaborative, by centralization of resources it is economical, through supervision and professional control, both explicit and implicit, the quality of service is protected. Social medicine, however, would present the added feature of voluntary or obligatory prepayment on an insurance basis for the cost of medical care, and to a very much greater degree than any teaching hospital social medicine would assume responsibility for home care, home visits and protective or preventive care. The controlling objective of socialized medicine is the welfare of each and all citizens: to accomplish this the physicians would have to be decently paid and the quality of their preventive, therapeutic and alleviating care would have to be supervised and controlled, the practice of medicine would have to be group practice in and radiating from hospitals acting also as health centers and places for educating the public. There is no likelihood that private practice would

disappear or be prohibited but it is certain that the great majority of persons not now reached by competent medical care would receive it. The transition from buying medical care as individuals and from individuals will follow different patterns. The full-time teaching hospital service is the first step. Group practice has already shown its value at the Mayo Clinic. Public health work as a government activity is already established. Prepayment hospital insurance against the costs of hospitalization is now gaining rapid and widespread acceptance. Probably the next advances will be in a somewhat similar insurance set-up to pay the services of physicians through voluntary agencies assuming some form of control over the quality and distribution of the doctors' work, as well as guaranteeing the stability of financing the cost. More detailed description cannot be forecast for social medicine is moving and changing in its concrete objectives and implementation.

Let us now turn to a variety of obstacles and objections to the methods and goals of social medicine. It might be noted that the obstacles are not the same as the objections as they are listed here, but both of course act as deterrents to any quick, orderly and intelligent change.

Among the obstacles, perhaps the first lies in the fact that incurable disease still exists in many and many an instance despite progress mentioned in the earlier part of this memorandum. When a patient has an incurable disease he and his family are not going to be content with the course of events and a reorganization of medical care runs the risk of offering a single target for the disappointment and recriminations that previously have been addressed to numerous physicians and surgeons individually. Then there is the obvious fact that change is met with reluctance and inertia in most fields of human endeavor. In this instance the medical profession, which in the main has enjoyed public

confidence and freedom from interference, can voice its reluctance with a considerable authority. As a technical obstacle to the development of insurance as a method of protection against the cost of illness, we have not until recently possessed sufficient figures on normal morbidity rates. We still lack experience to indicate the probable demand for physicians' services on any new plan of distribution. These figures would provide the essential basis for the organization of prepayment sickness insurance. Allowance must be made in the light of our general medical traditions for the dissatisfaction of some patients who have hitherto had economic margin enough to indulge in a relatively free choice of their physician. If it be admitted that social medicine will require a larger number of practitioners or a wider use of the time of existing doctors then the examples of professional incompetence or inadequate training will be cited as reasons against social medicine. Then, of course, it is true that some of the ablest and most active physicians possessing great prestige under the present system will face a loss of income and are opposed to change for this reason, though they would greatly resent such an imputation as to their motives. This in turn relates to the exceptional sensitiveness of the average physician to criticism. As has been said, "he is so surrounded by frightened patients, adoring families and obsequious nurses that he is not accustomed to having his opinion criticized by God or man." Certainly in point of political and public relations doctors are at a considerable disadvantage, especially in the United States where we have no General Medical Council to represent the interlocking interests of practitioners, public health officers, hospitals, boards of licensure and medical schools. In the United States each of these inter-related groups concerned with medical care has separate organizations and the American Medical Association, though it has a section devoted

to medical education, is in the main an organization representing merely a summation of the opinion and interests of county and state medical societies made up of private practitioners.

Among the objections to social medicine is the insistence that it would destroy freedom of the individual physician and the individual patient. No less active as an objection is the distrust felt by physicians of the political control and the concentration of power to determine the ways in which medical care will be brought to the lay public. It is predicted that social medicine will increase the inherent temptation of human nature to malingering, to become dependent on government and to abuse the protection to be secured by order of the physician. Representatives of the conservative and intransigent group warn the public that man must live by the sweat of his brow and offer other encomiums directed against the natural sloth and laziness of the human race. Somewhat more tangible are the claims that social medicine would impose upon each physician a number of patients larger than he could give adequate attention to, though this objection is based upon the assumption that the number of physicians could not or should not be enlarged if the contention proved valid. Lastly, there is bitter resentment because lay critics seem to impugn the motivation of the conservatives in rejecting social medicine and it is insisted that the physician has always given an exemplary amount of his services gratis.

Most of us can recall generous hard working unselfish doctors but the fact remains that the lower half of the population in point of income receives scarcely half the amount of medical care per family of that given to families of \$10,000 income. There are said to be 50,000,000 people with incomes below \$1,000 annually, and another 50,000,000 between \$1,001 and \$2,500. Certainly

to these people decent and effective medical care at a cost of \$100 to \$120 a year is not available.

The above considerations cover most of the issues and interests of social medicine. Insofar as medicine has secured new and reliable knowledge of the causes of diseases and of effective ways to cure them, the doctor faces a change in his relationship to his patients and the lay public generally. The status of the physician is changing from that of being a private luxury to becoming a public necessity.

The changes taking place are curiously similar to those characterizing the growth of the public school system in the United States. The concept of free public primary and secondary education, later followed by free universities, was extraordinarily inclusive in its sweep. It, too, was a radical departure from the traditions of an earlier day. Public school education was challenged by those who believed that education was an individual relationship and could not be made a mass affair. The cost of giving everyone a grammar school and a high school education was decried as unbearable and its practicability denied because of the inadequacy in numbers and training of teaching personnel. We have forgotten the long delays in the growth of public education, but after more than a half-century of effort, growth and improvement there has come a triumph for the original belief that a literate citizenry, even at a great cost, is the best guarantee of a democracy. What is wanting (though wartime demands more than suggest it) is a similar belief that a healthy citizenry is an equally important guarantee of a strong and effective nation.

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